

Sam Brownback  
Governor

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Executive Director



700 SW Harrison St. Suite 420  
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## CLINICAL ADDICTION COUNSELING LICENSURE GRANDPARENTING APPLICATION

### *Instructions*

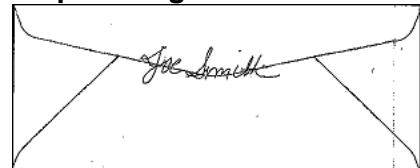
This form may only be completed if you hold or have held, between July 1, 2008 and June 30, 2011, an AAPS Credential, CADC I, II, or III, or RAODAC in the State of Kansas.

You must submit a complete application, which includes the following materials, or your application will be returned to you.

Please read all instructions and review the statutes and regulations, before beginning to complete the application. The statutes and regulations may be found on our website, [www.ksbsrb.ks.gov](http://www.ksbsrb.ks.gov).

1. **Application:** Please answer all questions on the application completely and accurately. If you answer yes to any questions in section VI, Background Information, additional information will be requested. If you have had any convictions, a background check will need to be sent directly to the Board from any state in which there was a conviction. This background check needs to be sent from the Kansas Bureau of Investigations (KBI), or the equivalent agency from any state where a conviction occurred. The background check may be sent to the Board office prior to your application.
2. **Fee:** The \$100.00 application fee must accompany your application. Make check or money order payable to "Behavioral Sciences Regulatory Board" or "BSRB". Credit card or cash, for the exact amount, are also accepted. **ALL FEES ARE NON-REFUNDABLE.**
3. **Professional References:** Two references are required as part of your complete application packet. The professional reference form included in the application packet will need to be copied.
  - a) Each reference should return the completed form to you in a sealed envelope with their signature across the seal. The two reference forms will need to be included when the application is submitted to the Board office. **NOTE: It is very important that references sign across the seal of the envelope or your application will be returned. (see example below)**
  - b) Each reference must be authorized to engage in the practice of addiction counseling or a related field. <sup>1</sup>
  - c) The references cannot be related to you and must be able to address your competence to perform the duties of an addiction counselor.
4. **Continuing Education:** You are required to have completed the following continuing education (CE) during the three years immediately preceding your application:
  - a) two hours in ethics;
  - b) two hours in confidentiality;
  - c) two hours in infectious disease; and
  - d) six hours in the diagnosis and treatment of substance use disorders.Submit your certificates of attendance or a copy of your transcript, with your application, to show proof that this requirement has been met. College credit may be used to meet this CE requirement.

**Example of signed sealed envelope:**



**5. Proof of Competency for Licensed Clinical Addiction Counselor:**

To grandparent to the clinical level you must meet requirements in route 1 or route 2:

**Route 1:**

- A) Hold or have held, within the last three years, an AAPS credential, CADC I, II, or III, or a RAODAC in the State of Kansas; and
- B) Currently hold one of the following:
  - i) A BSRB clinical independent license;
  - ii) a physician license to practice medicine and surgery; or
  - iii) a mental health advanced registered nurse practitioner.

**Route 2:**

- A) Hold or have held, within the last three years, an AAPS credential, CADC I, II, or III, or a RAODAC in the State of Kansas. (The Board has verification of this credential, therefore, no additional information is needed);
- B) hold a masters degree in a related field. NOTE: A transcript will need to be sent directly from the college or university to the Board office. <sup>1</sup> and
- C) have been actively engaged in the practice, supervision, or administration of addiction counseling in Kansas for at least four years. You will need to complete the Attestation of Experience found in the application and include proof of practice as requested on the form.

**6. Out-of-State Verification:** If you are or have ever been licensed, registered, or certified in one of the behavioral or health sciences in another state, a letter of good standing will need to be sent from the other state(s). This letter needs to be submitted directly to the Board office. **Only letters received directly from the other state(s) can be accepted.**

**7. Review:** It is extremely important for you to understand that the Board cannot determine whether you are eligible for a license until all of the application materials have been received and approved by the Board office.

Please allow 30 days for review of your application. **When your application has been reviewed you will be notified of your eligibility by mail or email.**

**When you submit your application to the Board office the following items must be included:**

- ☐ The completed and signed application form.
- ☐ The application fee of \$100.00 made payable to BSRB by cash, check, money order, or credit card.
- ☐ The two (2) completed Professional Reference Forms in their signed sealed envelopes to verify the seal hasn't been broken.
- ☐ Proof of completion of the required CEU's.
- ☐ The Attestation of Experience. (If applying through route 2)

**These additional items need to be sent directly to the Board office by the appropriate institutions:**

- ☐ A letter of good standing, if ever licensed in another state.
- ☐ An official transcript sent directly from your university to the board office. (If applying through route 2)

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<sup>1</sup> "Related field" may include, but is not limited to, education, criminal justice, counseling, healing arts, human development and family studies, human services, marriage and family therapy, nursing, psychology, social work, or theology.

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**CLINICAL ADDICTION COUNSELING GRANDPARENTING LICENSURE APPLICATION (LCAC)**

***Application***

**Application Fee as of January 1, 2012: \$100.00 cash, credit card, check, or money order payable to BSRB**

**I. Identifying Information: (Please type or print clearly in ink)**

**Legal Name:** \_\_\_\_\_  
Last First Middle

**Maiden/Other names used:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_ **(Note:** Your social security number is required pursuant to 42 U.S.C.S. § 666(a)(13), K.S.A. 74-148 and K.S.A. 74-139, and may be used for child support enforcement purposes or provided to the Kansas director of taxation upon request.)

**Ethnic Information:** African American \_\_\_\_\_ Native American \_\_\_\_\_ Asian Indian \_\_\_\_\_ Asian-Other \_\_\_\_\_  
(Optional) Hispanic \_\_\_\_\_ Pacific Islander \_\_\_\_\_ White – Non Hispanic \_\_\_\_\_ Other \_\_\_\_\_  
(Please Specify)

**Languages that you speak:** English \_\_\_\_\_ Spanish \_\_\_\_\_ Sign \_\_\_\_\_ Other \_\_\_\_\_  
(Optional) (Please Specify)

**Preferred E-Mail Address:** \_\_\_\_\_ **Preferred Mailing:** Home \_\_\_\_\_ Business \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone (optional):** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **Apartment Number:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip+4:** \_\_\_\_\_

**Business Phone:** \_\_\_\_\_ **Business Name:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_ **Suite Number:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip+4:** \_\_\_\_\_

**Address of Record:** **(Note:** The address of record is not required. It is a separate address that will be kept on file to be given out when requested by the public through the Kansas Open Records Act. If you do not indicate an address of record, your preferred mailing address will be used.)

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip+4:** \_\_\_\_\_

**\*\*Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP)\*\***

Are you willing to be included on a registry of potential volunteers to provide your professional services during an emergency? **Please check all that apply.**

Within your county of residence: \_\_\_\_\_ Within 75 miles of your residence: \_\_\_\_\_  
Anywhere in the State of Kansas: \_\_\_\_\_ Outside of the State of Kansas: \_\_\_\_\_

**II. Application/Licensure Information:** (Please **circle** yes or no)**A.** Provide the following information regarding your addiction counselor credential:

1. Name of Kansas credential: \_\_\_\_\_
2. Issue Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ (please attach additional sheet if needed)
3. Under what name: \_\_\_\_\_

**B.** Have you ever filed **any** application for licensure or registration in Kansas other than the credential listed above in question A?**Yes      No      If "yes", please answer the following questions:**

1. When: \_\_\_\_\_ For which credential: \_\_\_\_\_
2. Under what name: \_\_\_\_\_

**C.** Do you currently hold, or have you ever held a certificate, registration or license to practice in one of the behavioral or health sciences in another state or jurisdiction?**Yes      No      If "yes", please answer the following questions:**

1. For which credential: \_\_\_\_\_ In which state or jurisdiction: \_\_\_\_\_
2. Under what name: \_\_\_\_\_
3. Issue Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ (please attach additional sheet if needed)

**If you currently hold, or have ever held a certificate, registration, or license to practice in one of the behavioral or health sciences in another state or jurisdiction, you will need to have the former state Board(s) submit a letter of good standing directly to the board office.**

**III. Educational Information:****A.** List all educational institutions you attended beyond secondary level, their locations, the date of the degree(s) and the degree(s) granted. For additional education information please attach a separate sheet.

1. Name of School: \_\_\_\_\_
2. Location of School: \_\_\_\_\_
3. Degree Received: \_\_\_\_\_ Date of Degree: \_\_\_\_\_

**IV. References' Requirements:****A.** You must submit two completed reference forms, in their **sealed (signed across the seal)** envelopes, with your complete application. Your references should meet the guidelines as specified below:

1. The professional references must be authorized to engage in the practice of addiction counseling or to practice in a related field.
2. The professional references cannot be related to you and must be able to address your competence to perform the duties of an addiction counselor.

**B. References:**

Please print the requested information below for each of your references.

<b>Names</b>	<b>Credentials</b>	<b>Agency and Address</b>	<b>Phone Number</b>

**V. Continuing Education:**

Answer the following questions regarding the continuing education you have completed. You will need to submit your certificates of attendance or a copy of your transcript, with your application, to show proof that this requirement has been met.

Type	Title of Course	Number of Hours	Date of Completion
Ethics			
Confidentiality			
Infectious Disease			
Diagnosis & Treatment			

**VI. Proof of Competency for the Clinical Level of License:****Route 1.**

Provide the following information regarding your BSRB Clinical License:

1. Name of Kansas credential: \_\_\_\_\_
2. Issue Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_
3. Under what name: \_\_\_\_\_

**Route 2.**

1. Complete the Attestation of Experience and submit with your complete application.
2. You must have an official transcript showing completion of your master's degree in a related field sent directly from your college or university to the board office.

**VII. Background Information:**

Please **circle** either "yes" or "no" to the following questions. **If you answer "yes"**, please attach a detailed written explanation. Additionally, if you have been convicted of a crime a criminal background check will be required. See the instruction page for more information.

1. Have you ever been convicted of a felony?  
**Yes      No**
2. Have you ever been convicted of a misdemeanor crime against persons?  
**Yes      No**
3. Have you ever been found guilty of or liable for fraud or deceit in connection with services rendered as an addiction counseling service provider by a civil or criminal court of law or board of a professional organization?  
**Yes      No**
4. Have you ever knowingly aided or abetted a person, not a licensed addiction counselor, in representing him/her as a licensed addiction counselor?  
**Yes      No**
5. Have you used any alcohol, narcotic, barbiturate other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent within the last 2 years?  
**Yes      No**
6. Have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice behavioral sciences with reasonable skill and safety within the past 2 years?  
**Yes      No**

7. Have you used controlled substances which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the direction of a licensed health care provider within the past 2 years?  
**Yes      No**
8. Have you ever been found to be in violation of a professional association's code of ethics or of a state licensing board's rules and regulations or statutes regarding professional conduct?  
**Yes      No**
9. Have you ever paid a judgment or settlement in a negligence action that concerned your addiction counselor profession?  
**Yes      No**
10. Have you ever resigned from a professional association, withdrawn from an undergraduate or graduate program or surrendered your license to a state licensure board while an ethical complaint was pending against you?  
**Yes      No**
11. Have you ever identified yourself as an addiction counselor in Kansas (excluding student work)?  
**Yes      No**
12. Has any governmental agency ever substantiated allegations made against you for physical, mental or emotional abuse or neglect, sexual abuse, or exploitation of (1) a child, (2) a resident of an adult care home, medical care facility, psychiatric hospital or state institution for the mentally retarded, or (3) an adult?  
**Yes      No**

### VIII. Applicant's Attestation:

Please **circle** either "yes" or "no" to the following questions.

1. I have reviewed the licensure eligibility requirements prior to submitting this application.  
**Yes      No**
2. I have completed the application materials and procedures honestly and in good faith.  
**Yes      No**
3. I understand that the members and staff of the BSRB are compelled by law to uphold, implement, and enforce the licensure statutes and regulations as written.  
**Yes      No**
4. I understand that all state records pertaining to application and licensure may be used to conduct research or program evaluation, but such research will not personally identify the applicants or licensees, either directly or indirectly.  
**Yes      No**
5. I understand that the Board has the statutory authority to refuse to grant licensure to, or may suspend, revoke, condition, limit, qualify, or restrict the license of any individual that has knowingly made a false statement on a BSRB form required for licensure or renewal.  
**Yes      No**
6. I **have read** and am familiar with the statutes and regulations that govern the practice of addiction counseling in the state of Kansas.  
**Yes      No**
7. I understand that **once the Board receives my application I am bound by the statutes and regulations governing the practice of addiction counseling in Kansas.**  
**Yes      No**

**I hereby affirm that to the best of my knowledge all my answers to the foregoing are correct. I further agree that all state records pertaining to my application and licensure may be used to conduct research or program evaluation, provided that the research does not personally identify me, directly or indirectly.**

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SIGNATURE OF APPLICANT

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DATE OF APPLICATION

**NAME or ADDRESS CHANGE:** It is the applicant's responsibility to notify the Board in writing of any name or address change that might occur during the application process.



**APPLICATION FOR CLINICAL ADDICTION COUNSELING GRANDPARENTING LICENSURE (LCAC)**

***Professional Reference Form***

**Instructions for the applicant:** Please complete **Section I** and submit to the referencing individuals for completion. Additional copies of this form may be made and used as needed. Completed Professional Reference forms shall be submitted **in the unopened signed, sealed envelopes** as part of your complete application packet.

**Instructions for the reference:** Please complete **Section II**. Place the completed reference form in an envelope, **sign across the seal** and return to the applicant.

**Section I:** This section is to be completed by the applicant.

**To:** (Name of reference-please print) \_\_\_\_\_

**From:** (Name of Applicant-please print) \_\_\_\_\_

I am applying for licensure as an addiction counselor in the State of Kansas and I am required to provide information to support that application. This form, bearing my signature, gives my consent and authorization to release any and all information and/or documents that may be material to an evaluation of my merit of the public trust. I authorize the Behavioral Sciences Regulatory Board (BSRB) and its representatives to consult with you regarding my professional competence, character, ethical qualifications, health status, ability to work cooperatively with others and other qualifications for licensure.

I release from liability any and all individuals, institutions and organizations that provided information to the BSRB or its representatives, in substantial good faith and without malice, concerning my merit of the public trust and my qualifications for licensure. I consent to the inspection by the BSRB and its representatives of all documents that may be material to an evaluation of my qualifications and competence. I understand that this consent for release of information will be in effect for a period of one year from the date of consent.

Please mail this completed form directly to me in a sealed envelope with your signature across the seal. **Please be certain to seal the envelope and sign over the seal.** I am responsible for submitting to the BSRB the completed form in its sealed envelope as part of my application packet.

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Section II:**

Please answer **all** questions to the best of your knowledge. Return this completed form to the applicant in a sealed envelope with your signature across the seal of the envelope to insure confidentiality.

To qualify to serve as a professional reference, the referencing individual must be:

1. Unrelated to the applicant;
2. able to address the applicant's professional conduct, competence, and merit of the public trust;
3. authorized to engage in the practice of addiction counseling or to practice in a related field.

**Note:** If you do not qualify to serve as a professional reference, please alert the applicant.

**I. Professional Reference's Information:**

- A. Name: \_\_\_\_\_
- B. Business Name: \_\_\_\_\_
- C. Street Address: \_\_\_\_\_
- D. City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- E. Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
- F. Educational Background: \_\_\_\_\_ Professional Title: \_\_\_\_\_
- G. Do you hold a Professional Credential? Yes \_\_\_\_\_ No \_\_\_\_\_ **If "yes", please answer the following questions.**
1. Professional Credential Held: \_\_\_\_\_ Credential #: \_\_\_\_\_
2. State of Issuance: \_\_\_\_\_ Issuance Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**II. Please circle yes or no to following questions.**

- A. What relationship (such as employer, supervisor, co-worker, instructor) have you had with the applicant which has aided you in forming any opinion of his/her character: \_\_\_\_\_
- B. Have you supervised the applicant in a work setting?  
**Yes No If yes please list the dates you supervised the applicant.**  
**Beginning Date:** Month \_\_\_\_\_ Year \_\_\_\_\_ **Ending Date:** Month \_\_\_\_\_ Year \_\_\_\_\_
- C. Are you related by blood or marriage to the applicant?  
**Yes No If yes, please state relationship to the applicant.** \_\_\_\_\_
- D. How long have you known the applicant? \_\_\_\_\_

**III. Professional Reference's Knowledge of Applicant: (Please circle yes or no)**

- A. Please consider the candidate's behavior in the following areas: good judgment, integrity, honesty, fairness, credibility, reliability, respect for others, respect for the laws of the state and nation, self-discipline, self-evaluation, initiative, and commitment to the addiction counseling profession and its values and ethics. Does the candidate, in your opinion, possess the moral standards and fitness required for working as an addiction counselor?  
**Yes No If your answer is "no", please elaborate in detail in an attached statement.**
- B. Are you aware of any significant facts concerning the applicant's background that would reflect **unfavorably** on the applicant's character and fitness to practice addiction counseling?  
**Yes No If your answer is "yes", please state these facts in detail on an attached statement.**
- C. Do you recommend the applicant for licensure to practice addiction counseling in Kansas?  
**Yes No If your answer is "no", please elaborate in detail in an attached statement.**
- D. **If you have known the applicant for less than 6 months** please list some specific examples of what you have witnessed that allows you to make the above mentioned determinations.

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- E. Please expand or add any comments or information that you believe will aid the Behavioral Sciences Regulatory Board (BSRB) in evaluating the applicant's ability to practice addiction counseling and merit of public trust for licensure as an addiction counselor in Kansas.

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**IV. Professional Reference's Attestation:**

Reference's Attestation: I certify the foregoing answers and information furnished above are given in good faith with the understanding that it will be utilized for purposes of determining the applicant's ability to practice addiction counseling and merit of the public trust in order to be licensed as an addiction counselor in the State of Kansas. Any response or information I have provided is true and correct to the best of my knowledge and belief. Where I have relied upon other sources of information, they are only those which I believe to be accurate and reliable.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



CLINICAL ADDICTION COUNSELOR GRANDPARENTING APPLICATION (LCAC)

*Attestation of Experience*

Please complete the following information and submit the form with your complete application:

**I. Experience Information:**

Name \_\_\_\_\_

Lic/Reg/Cert Type \_\_\_\_\_ Lic/Reg/Cert # \_\_\_\_\_

I \_\_\_\_\_, attest that I have engaged in the professional practice, supervision, or administration of addiction counseling in Kansas for at least four years, which included an average of at least eight hours per week for 9 months in each of the four years.

Complete the following information for each work site you where you have practiced during the four years. Attach an additional sheet if necessary.

Business Name \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Dates Worked at This Site \_\_\_\_\_  
Start Date (MM/DD/YY) End Date (MM/DD/YY)

Description of Addiction Counseling: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Business Name \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Dates Worked at This Site \_\_\_\_\_  
Start Date (MM/DD/YY) End Date (MM/DD/YY)

Description of Addiction Counseling: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Business Name \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Dates Worked at This Site \_\_\_\_\_

Start Date (MM/DD/YY)

End Date (MM/DD/YY)

Description of Addiction Counseling: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## II. Applicant's Attestation

**I hereby affirm that to the best of my knowledge all my answers to the foregoing are correct. I further agree that all state records pertaining to my application and licensure may be used to conduct research or program evaluation, provided that the research does not personally identify me, directly or indirectly.**

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

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## Credit Card Payment Form

**Only complete when paying by credit card.**

*The credit cards accepted are American Express, Discover, MasterCard and Visa.*

Amount of Purchase: \$\_\_\_\_\_

Credit Card: American Express \_\_\_\_\_ Discover \_\_\_\_\_  
MasterCard \_\_\_\_\_ Visa \_\_\_\_\_

Credit Card Acct. # \_\_\_\_\_

Credit Card Expiration Date \_\_\_\_ / \_\_\_\_

Name as it appears on the card \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

### For Office Use Only:

Approval Number \_\_\_\_\_ Date \_\_\_\_\_